State of Hawaii
Department of Health

Child and Adolescent
Mental Health Division

Performance Improvement Recommendations:
Addendum to Annual Evaluation Report Fiscal Year 2004

Prepared by
Eric L. Daleiden, Ph.D.

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Purpose

The purpose of this report is to summarize recommendations for potential avenues to improve the quality and comprehensiveness of services provided by the Hawaii Child and Adolescent Mental Health Division (CAMHD). These recommendations stem from the review and discussion of the CAMHD Annual Evaluation Report for Fiscal Year 2004. The annual evaluation results have been presented and discussed at several CAMHD stakeholder meetings including the State Council on Mental Health, CAMHD Performance Improvement Steering Committee (PISC), CAMHD Statewide Management Team, CAMHD All Staff Meeting, and Honolulu District Interagency Quality Assurance Committee. Comments and suggestions from these meetings were combined with the results of a detailed discussion by a PISC workgroup assembled for this purpose. The workgroup consisted of the following persons:

Keli Acquaro, M.A.	Hawaii Family Guidance Center Branch Chief
Al Arensdorf, M.D.	CAMHD Medical Director
Eric Daleiden, Ph.D.	CAMHD Research and Evaluation Specialist
Jim Ford, MC/MFT, CSAC	Marimed Provider Representative
Ana Rosal, M.Ed	Catholic Charities Provider Representative
Mike Wurtz, L.S.W.	PACT Provider Representative

Information from these different sources was assembled and compiled by the author of this report and responsibility for any errors of omission or misrepresentation resides with the author, but the opinions expressed are not necessarily those of the author. The offering of these numerous recommendations should not be construed as a belief that all of these recommendations could be feasibly implemented. On the contrary, careful selection of key initiatives and implementation of well-defined improvement programs with sufficient dosage was recommended.

Recommendations

Population Size

As in prior years, considerable discussion focused on strategies for increasing CAMHD's overall client population and improving the availability of services. Continued emphasis was placed on the expansion of CAMHD's Supporting Emotional and Behavioral Development (SEBD) program as a key mechanism for growth in addition to promoting earlier referral through the school-based peer review referral process.

Community Outreach

Much discussion focused on the need to increase community outreach and the types of community outreach that might be fruitfully expanded. Increased SEBD enrollment was attributed in part to the regional meetings between Family Guidance Center (FGC) Branch Chiefs and Department of Human Services (DHS) Administrators. It was recommended that these meetings continue and evolve their role to move past crisis referrals and emphasize co-management of cases between DHS and CAMHD. In addition, it was recommended that participants in these regional meetings consider expanding membership to include direct supervisors in addition to administrators to promote earlier identification and referral of youth with problematic, but less severe functional impairment.

It was further recommended that outreach efforts to DHS include DHS eligibility workers in addition to Child Protective Services (CPS) personnel. CAMHD could offer focused training to DHS eligibility workers regarding the SEBD referral process and to encourage eligibility workers to perennially ask the questions "how are things with your children" during meetings with parents. CAMHD should also consider partnering with broader Med-QUEST initiatives (e.g., Hawaii Covering Kids) to promote inclusion of more information about mental health

services for youth. Discussion also centered on the importance of retention of youth and families once enrolled in the SEBD program, but specific initiatives were not identified.

In addition to DHS, continued training in the referral process was recommended for other agencies that serve the QUEST population and are thus potential referral sources. The completion of the SEBD brochure was a positive development and it was recommended that wide spread mailing of the brochure to stakeholders be performed (e.g., health centers, community centers, faith organizations, nonprofit agencies, etc.).

FGC Clinical Directors and Clinical Psychologists were identified as two key groups that could play a very important role in outreach into the community. Specifically, it was recommended that these FGC clinical leaders focus on networking and outreach with professional groups, county medical societies, early childhood groups, and primary care physicians. One specific suggestion was that FGC professionals should join the hospital staff in their areas.

Identify Triggers for Peer Review

As in prior years, the efficiency and effectiveness of the peer review and referral process between the Department of Education (DOE) and the Department of Health (DOH) was a focus of discussion. To promote earlier identification of youth eligible for CAMHD services, CAMHD should work with the regional Quality Assurance Committees to create clear guidance for referrals. It was recommended that a set of criteria or "triggers" be identify that automatically trigger peer review of a case. For example, specific thresholds could be identified for truancy, drop in grade point average (GPA), type of disability identified on an Exceptions to Compulsory Education Form (4140), and number of days of disciplinary suspension.

Promote Stakeholder Awareness of Strengths and Developments in SEBD Program

Another potential barrier to referral is that potential referral sources may be unclear how severe problems must be before a youth would qualify for CAMHD services. Therefore, it was recommended that CAMHD develop and disseminate a series of youth descriptions that "put a face" what a qualifying case looks like compared to more or less severe problems. The goal would be to provide clear prototypes about what appropriate referrals look like that would help potential referral sources identify similar youth. Such case illustrations may be relatively easy to retrieve from case books, instrument manuals, etc. Once developed, it is recommended that these illustrations be posted on the website, added to the brochure, and included in ongoing training.

It was also recommend that in additional marketing efforts for the SEBD program, emphasis be placed on the fact that SEBD provides a free service to families and is not committing families to additional financial investment. Also, the upcoming expansion of the outpatient service array was thought to provide an opportunity for making it widely known that youth with significant emerging problems can be served through CAMHD in addition to youth with problems that have reached crisis proportions.

Conduct Disorder and Its Precursors

Again consistent with prior years, conduct disorder was identified as a priority population for prevention and intervention efforts.

Provide concrete guidance for referrals

The first recommendation related to conduct problems called for identification of clear criteria that would trigger referral for evaluation or services. Two candidate criteria were (a) any youth identified as "challenging" from a parenting perspective, and (b) juvenile justice involvement before age 13 years. Discussion emphasized that many of the "early starter" conduct problems might be identified in childhood based on problematic relations with parents.

In addition, it was suggested that CAMHD should collaborate with family court to refer for further evaluation any youth presenting to the court prior to age 13 years.

Expand service array

Second, moving forward with expanding outpatient and services to younger (early intervention) groups was strongly support to challenge view that CAMHD is just for the "most severe" youth. In addition to challenging this obstacle to early intervention, strong support was noted for the practice development plan to bring in addition evidence-based services for disruptive behavior such as Multidimensional Treatment Foster Care and Functional Family Therapy. As development of these new programs move forward, it is recommended that clear priority be given to integration of these new programs with the broader service array to avoid the risk of creating new "programmatic silos."

Expand Family Intervention

The third recommendation emerged in the context of addressing conduct problems, but was expected to be more generally applicable, namely that CAMHD should actively promote expanded family intervention. CAMHD should systematically emphasize family engagement at all levels of care and emphasize specific supports that promote family involvement, such as ensuring availability of transportation, ensuring program availability in high need geographic areas, etc. Further, it was recommended that CAMHD should readily "step forward" to provide family services when DOE identifies this as a need and CAMHD should not expect DOE to try to arrange these services in the context of school-based behavioral health if challenges arise.

Systematically Expand Leverage from Legal System in Productive Ways

Discussion also addressed how interactions between mental health service personnel and the legal system has the potential either to productively motivate treatment engagement and emphasize consequences for problematic behavior or to cause friction with mental health service goals (e.g., mental health professionals calling law enforcement to perform crisis management rather than managing within the therapeutic community). It was recommended that rather than relying on a "Letter of detainment" or calling law enforcement when problems arise, CAMHD should generate a list of alternative means for engaging courts and incorporating legal consequences in treatment. It was specifically noted that Multisystemic Therapy has used a number of very creative strategies for productively engaging the legal system in the treatment of misconduct. Documentation and dissemination of examples of these strategies might make these options more accessible across the CAMHD service array. Other recommendations for additional productive engagement with the legal system included nominating topics for annual judges meeting if possible and continuing efforts to focusing on a therapeutic rather than containment or coercion culture throughout the mental health and justice systems.

Long-Term Planning from First Day of Treatment

In addition to the preceding recommendations for intervention, considerable discussion highlighted the ongoing need for enduring long range planning throughout the treatment. Currently, coordinated service plans (CSPs) include transition plans and the quality review of CSPs includes evaluation of those plans in addition to an item on a long-term view, but additional investment by care coordinators and service providers was viewed as necessary to bring these plans to fruition. Additional partnerships with other community agencies that are not formally part of the current CAMHD service network seem essential for long-term success. In particular, recommendations were made to expand vocational programming system-wide, to link more closely with General Education Development (GED) preparation programs, and to identify sustainable self-sufficiency pathways beyond traditional education. It was particularly suggested that CAMHD examine the current independent living program array to identify its sufficiency and the opportunities it provides for expanding vocational services. Many youth with conduct disorders in the current CAMHD population are adolescents so there appears to be an immediate need for expanding long-term options for these youth. The CASSP value of family reunification was reaffirmed in discussion, but caution was raised that CAMHD should remain vigilant to helping those youth for whom

reunification will not become a reality. Additional options that promote self-sufficiency for these youth merit further development.

Community-Based Residential Services

The number of youth receiving community-based residential services at some point during the fiscal year continued to show a dramatic increase. This remained a high priority issue for discussion with differing views as to whether this state of affairs is problematic and merits targeted reduction or whether it reflects a reasonable adaptation to the current circumstances facing the system and merits expansion of this popular service.

Clarify Strategic Focus

If the differing views expressed during discussion reflect a broader commitment to action, successful implementation of any large-scale initiative aimed at altering CBR utilization may be unlikely to succeed. It was recommended that in this environment efforts should focus on "creating a space" for stakeholder debate and clarification of values. Accordingly, it was recommended that some type of systematic stakeholder discussion be organized to clarify whether reduced utilization of CBR services should be a core strategic goal.

Continue to Generate Alternatives and Facilitate Transitions

Despite the debate, a number of recommendations emerged from discussion of CBR utilization. Whether or not the rate of CBR service use was of concern, consensus generally emerged that CAMHD should actively maintain comprehensive service array that provides youth with alternative treatments to support smooth transitions out of the CBR when appropriate. Anecdotal reports described how youth may plateau within a given setting and that it is essential to efficiently move youth to other services before treatment creates new problems for youth. Additional recommendations for promoting transitions within the service array include purposefully contracting for multiple levels of care within provider agencies, developing an incentive system that promotes cross-agency collaboration, and encouraging home and community based service providers to meet with youth and begin services prior to termination of residential services.

Discussion noted that CAMHD's current administrative reports (e.g., weekly census) provide considerable information about the capacity and occupancy of out-of-home services, but that managers and supervisors do not have ready access to regional information about the capacity and occupancy of home and community based services. Therefore, it was recommended that CAMHD expand capacity-occupancy reports for in-home services in addition to the regular provider census reports that are currently provided for out-of-home services. This addition might help keep in-home services "on manager's radar screen" at the same level as out-of-home services

It was recommended that CAMHD should seriously address the question of "Why not build greater capacity?" The current system goal seems to be to maintain a relatively close matching between contracted capacity and actual occupancy. It was recommended that CAMHD consider performing a detailed analysis of the added expense necessary to bias the system toward investing in excess capacity rather than very actively managing capacity to current population. The fiscal and human costs associated with delays in adjusting contracts to expand service capacity at the time a service is needed should be balanced against the cost of maintaining unused capacity.

To the extent that treatment teams are currently "voting" their preference through their service procurements, CAMHD should be prepared to respond to continued demand for CBR and other out-of-home services. Given the enduring growth rates in CBR services in particular and out-of-home services in general, it is likely that new facilities will be needed. It is recommended that CAMHD's interagency partners be actively engaged in such planning in the near future. Particularly, it was recommended that strong school districts be identified and engaged in building future programs, that district personnel be engaged early in the conversation about where to build programs, and that CAMHD support discussions about adding resources to these districts (e.g., alternative learning classrooms, skills trainers, etc.). Models from other places were cited (e.g., Albuquerque & Reno) as examples of resource systems that balance investments by school districts. For example, any school district that

places a youth outside of itself must self-pay for all services, not just education services to the school district providing the services.

Providers and Workforce

The final set of recommendations related to continued development and engagement of CAMHD's provider network and expansion of the state's workforce capacity.

Continue Engaging Providers in System Planning

Discussion repeatedly noted the CAMHD has made numerous efforts to expanded provider engagement, communication, and representation that has resulted in increased provider participation in recent years. All stakeholders identified this as a positive trend and anecdotal reports indicated that provider participation has helped advance several "perennial" discussions that had "grown stagnant." It was recommended that CAMHD continue its active efforts to engage providers on committees and workgroups through extending invitations, supporting travel, maintaining consistent and convenient meeting times, incorporating multiple telecommunication channels (e.g., teleconferencing & email), etc.

Workforce Development

Recommendations related to workforce development focused on two primary issues – expanding the overall mental health workforce and increasing the skill of the existing workforce. Discussions of expanding the overall workforce emphasized encouraging and helping both new professionals and new foster families into the field. Public presentations by CAMHD personnel to numerous stakeholder groups that provide a clear indication of what works for youth (evidence-based services) and about CAMHD's population, services, and results were consistently perceived as productive efforts that should be continued. It was recommended that CAMHD expand partnerships with the many local universities to extend curricular offerings, practicum, and internship experiences to cover the topics and types of services of most relevance to the current system of care. Due to consistent challenges with recruiting foster families, it was recommended that CAMHD share responsibility for foster family recruitment rather than completely delegating this function to provider agencies. CAMHD should also consider partnering with the Department of Human Services to participate or lead a statewide initiative to market and recruit foster families, including therapeutic foster families.

Discussion consistently noted CAMHD's strong history of investing training and development resources to promote skill development throughout the system. It was recommended that CAMHD continue to seek out and invest in training and development activities. The movement toward expanded analysis, peer support, and mentoring of front-line supervision activities was viewed as a positive step for evolving beyond general conferences and didactic training in practice development. The integrated presentation of the evidence-based services and actual care profiles in the annual evaluation was very favorably received and promoted extensive discussion. It was recommended that this information be widely disseminated through presentation to stakeholders, particularly service provider groups, and that this type of information be integrated where feasible into CAMHD's extant training curricula.

Summary

The CAMHD system continues to evolve, but major structural changes have seemed to stabilize over the last few years. In the face of this temporary stability, a few key issues have emerged as focal points for recommended action over the past two years – outreach to promote access to services and early intervention, improved services for conduct-related disorders, and managing community residential services and related transitions. In addition, development of service providers and families as central resources for improving service quality and capacity was emphasized in this year's recommendations.